

Electronic Data Interchange (EDI)

- Supervisor must file claims Electronically with EDI within 2 working day of employee notice
- Filing Claims Electronically
<https://extranet.apps.cpmss.osd.mil/Divisions/Benefits%20and%20Worklife/Injury%20and%20Unemployment%20Compensation%20Branch/Online%20Tools%20Overview/DIUCS%20Supervisor%20Link.aspx>
- Supervisor should call or email ICPA regarding notification on electronic posting
- Supervisor should forward any Medical Documentation received from employee to

Electronic Data Interchange (EDI)

- ❑ It has been DoD policy since July 2003 to utilize EDI when submitting claims
- ❑ DOL will be monitoring agency timeliness for claim submission as a result of SHARE
- ❑ Defense Safety Oversight Council (DSOC) will be monitoring DoD agency timeliness and use of EDI for claim submission

Electronic Data Interchange (EDI)

- ❑ Claims filed utilizing EDI are electronically transmitted to OWCP from the agency
- ❑ Any delay due to internal routing of paper claims and mailing forms to OWCP are eliminated

CLAIM PROCESS

- Employee reports the injury to his/her supervisor
- Process is started by accessing the EDI website
- Supervisor and employee complete the electronic form, which is transmitted to the ICPA. Supervisors do not need any special access to file the claim electronically, only a computer with internet access

CLAIM PROCESS

- ❑ ICPA receives an email notification of the supervisor's claim submission
- ❑ ICPA will receive, via email, a copy of the OSHA 301 to forward to the appropriate Safety Office if that Safety Office does not have an established alias

CLAIM PROCESS

- ICPA “authenticates” the form (i.e. verifies employment status, enters appropriate codes, corrects any errors); form is then transmitted to DOL
- If there are no problems with the claim, the ICPA will receive an email with the case number within 2-3 business days
- If there are problems with the claim then the ICPA will receive an email notification of the claim rejection and the reason for the rejection

CLAIM PROCESS

- ❑ If there are problems with the claim then the ICPA will receive an email notification of the claim rejection and the reason for the rejection
- ❑ The EDI forms are patterned directly on the hard copy forms CA-1 and CA-2. Therefore, the basic instructions for completing the forms are the same as with paper

DIUCS: Supervisor Link - Windows Internet Explorer

https://extranet.apps.cpms.osd.mil/Divisions/Benefits%20and%20Worklife/Injury%20and%20Unemployment/ICUC/OnlineTools/

File Edit View Favorites Tools Help

Favorites ACPOL-CPOL Homepage ... AKO Army Knowledge Online ASAP IPR CHRA AKO CPMS-CARE Home Page ... CPOL Portal 8.1 Desktop

DIUCS: Supervisor Link

DEPARTMENT OF DEFENSE
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Home » Our Divisions » Benefits and Work Life Programs » Injury and Unemployment Compensation (ICUC) Branch » Online Tools Overview » DIUCS: Supervisor Link

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ICUC NAVIGATION

- [Injury Compensation](#)
- [Unemployment Compensation](#)
- [Pipeline](#)
- [Training Opportunities](#)
- [Online Tools](#)

ONLINE TOOLS NAVIGATION

- [Overview](#)
- [DIUCS Database](#)
- [DIUCS System Access & Implementation](#)
- [DIUCS Supervisor Link](#)
- [DIUCS for ICPAs](#)
- [Learning Management System Access & FAQ](#)
- [Filing CA-1/CA-2 Online](#)
- [Filing CA-3/CA-7 Online](#)
- [Request and ICUC Data Report](#)

Trusted sites | Protected Mode: Off

100%

EDI FORM

Disclaimer [View Disclaimer](#) [Print Disclaimer](#) [Close](#)

This DoD computer system including all related network devices (specifically including internet access) are under U.S. Government use. DoD computer systems may be monitored, including to ensure authorized use, for system management, to facilitate protection against unauthorized access, and to verify security procedures, survivability and operational security. Monitoring includes active attacks by authorized DoD entities to test or verify the security of this system. During monitoring, information may be examined, recorded, copied and used for authorized purposes. All information, including personal information, placed on or sent over this system may be monitored. Use of this DoD computer system, authorized or unauthorized, constitutes consent to monitoring. Unauthorized use may subject you to criminal prosecution. Evidence of unauthorized use collected during monitoring may be used administrative, criminal or other adverse action.

OK

Cancel

EDI FORM

Supervisor Entry ✖

Enter A New U.S. Department of Labor Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN):

Date of Birth (MM/DD/YYYY):

Enter employee's SS# without dashes, form will automatically place them for you

Claim Form Type

CA1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation

CA2 Notice of Occupational Disease and Claim for Compensation

Choose correct Claim Form Type

Enter claim **Exit**

EDI/SaFER V1.35 07/26/06

EDI FORM

DIUCS v2.1 EDI

Window

Supervisor Entry

ORACLE

Enter A New U.S. Department of Labor Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN): **111-11-1111**

Date of Birth (MM/DD/YYYY): **01/01/1960**

Claim Form Type

CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation

CA-2 Notice of Occupational Disease and Claim for Compensation

Enter claim

Once the employee's information is added, select the **Enter claim** button to begin entering data.

saf 01.

Record: 1/1

Warning: Applet Window

EDI FORM

EDI CS v2.1 EDI

Window

EDI CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH, First Name: JOHN

Middle Name: Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex

Male Female

5. Home Phone

6. Grade as of date of injury

Level: WG10 Step: 05

7. Employee's home mailing address

Street Address:

City:

State: ZIP Code:

8. Dependents

Wife, Husband
 Children under 18 years
 Other

Claim information

EDI claim number:

Status:

Trading partner ID: FECAEDI

Status time:

Record: 1/1

Warning: Applet Window

The form will now open with the employee's information populated into the appropriate fields using data from the personnel system.

EDI FORM

EDI CS v2.1 EDI

Window

EDI CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH First Name: JOHN

Middle Name: Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex

Male Female

5. Home Phone

6. Grade as of date of injury

Level: WG10 Step: 05

7. Employee's home mailing address

Street Address:

City:

State: ZIP Code:

8. Dependents

Wife, Husband
 Children under 18 years
 Other

White fields are required to be filled in.

Yellow fields are optional and do not have to be filled in, with the exception of 8. Dependents

Gray fields are informational and cannot have data entered into them.

Claim information

EDI claim number:

Trading partner ID: FE

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH First Name: JOHN

Middle Name: (not entered) Suffix: 111-11-1111

2. Social Security Number

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex

Male Female

5. Home Phone

(123) 455-7890

6. Grade as of date of injury

Level: WG10 Step: 05

7. Employee's home mailing address

Street Address:

City:

State: ZIP Code:

8. Dependents

Wife, Husband
 Children under 18 years
 Other

Claim information

EDI claim number:

Trading partner ID: FECAEDI

Some fields require the data entered to be in a particular format. For example, phone numbers should be entered **without** using any brackets () or hyphen (-)

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CAT

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH First Name: JOHN

Middle Name: (not entered) Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex

Male Female

5. Home Phone

(123) 455-7890

6. Grade as of date of injury

Level: WG10 Step: 05

7. Employee's home mailing address

Street Address:

City:

State: ZIP Code:

8. Dependents

Claim information

EDI claim number: Status:

Trading partner ID: FECAEDI Status time:

FRM-40209: Field must be of form FM9999999999999999. Record: 1/1

Welding Applet Window

If data is entered into a field using the wrong format, the application will not let the user move forward until the data is correctly entered. A message will be provided at the bottom of the screen to inform the user as to what needs to be done to fix the format problem.

EDI FORM

DIUCS v2.1 EDI

Window

EDI CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH First Name: JOHN

Middle Name: Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex

Male Female

5. Home Phone

123456789

6. Grade as of date of injury

Level: WG10 Step: 05

7. Employee's home mailing address

Street Address: 123 MAIN STREET

City: ANYTOWN

State: FL ZIP Code:

8. Dependents

Wife, Husband
 Children under 18 years

Claim information

EDI claim number:

Status:

Trading partner ID: FECAEDI

Status time:

Display List of Corresponding Zip Codes - Press CTRL+L

Record: 1/1 ...

Warning: Applet window.

A message will also be displayed at the bottom of the screen when a dropdown box is available for a field. Fields with Zip Codes have this function. To activate the box, place the cursor in the field and hold down the CTRL and L keys at the same time.

EDI FORM

DIUCS v2.1 EDI

Window

EDL_C1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1

1. Name of employee
Last Name: SMITH

Middle Name: Suffix: (not entered) 111-11-1111

3. Date of birth MM-DD-YYYY 01-01-1960

4. Sex Male Female

5. Home Phone

6. Grade as of date of injury Step: 05

7. Employee's home mailing address
Street Address: 123 MAIN STREET
City: ANYTOWN
State: FL ZIP Code:

Claim information
EDI claim number:
Trading partner ID: FECAEDI

A box will appear that allows the available entries in that field to be searched

Listing of Zip Codes

Find FL%

STATE	CITY	ZIP CODE
FL	FLEMING ISLAND	32006
FL	ORANGE PARK	32006
FL	BOSTWICK	32007
FL	BRANFORD	32008
FL	BRYCEVILLE	32009
FL	CALLAHAN	32011
FL	DAY	32013
FL	LAKE CITY	32024
FL	LAKE CITY	32025
FL	FLORIDA DEPT OF CORR	32026

Find OK Cancel

Choices in list: 2629
Record: 1/1 ...

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CAI

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

1. Name of employee

Last Name: SMITH First Name: JOHN

Middle Name: Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex

Male Female

5. Home Phone

7. Employee's home mailing address

Street Address: 123 MAIN STREET

City: ANYTOWN

State: FL ZIP Code:

Claim information

EDI claim number:

Trading partner ID: FECAEDI

Listing of Zip Codes

Find FL%

STATE	CITY
FL	FL MING ISLAND
FL	ORANGE PARK
FL	BOSTWICK
FL	BRANFORD
FL	BRYCEVILLE
FL	CALLAHAN
FL	DAY
FL	LAKE CITY
FL	LAKE CITY
FL	FLORIDA DEPT OF CORR

Find OK Cancel

Choices in list: 2629

Record: 1/1

Warning: Applet Window

ORACLE

Entering a state before the % (I.e. FL%) will display all the Zip Codes for that state

Entering a State before the % and city after (I.e. FL%Miami) will display all the Zip Codes for that city.

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CAI

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

MAIN OFFICE BUILDING, 1223445 WORK STREET, ANYTOWN FL

FLEMING ISLAND FL ZIP Code: 32006

10. Date & time injury occurred
MM-DD-YYYY HH:MM [AM|PM]
01-20-2005 02:30 PM

11. Date of this notice
MM-DD-YYYY
01-20-2005

12. Employee's Occupation Description
MAIL CLERK

13. Cause of injury (Describe what happened and why)
I WAS WALKING DOWN THE STAIRS AND I TRIPPED AND FELL

14. Nature of injury (Identify both the injury and the part of body)
BROKEN NOSE, BRUISED RIBS

The employee's information will be entered into the system. Pay particular attention to fields that require a date and time such as Block 10. If no time is entered in the block, the time will default to 12:00 am.

Anatomical location code

Part of Body Side of Body

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CAT

ORACLE

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand I may be entitled to sick leave or annual leave, or be deemed an overpaid employee.
 b. Sick and/or Annual Leave
 c. Unknown

The employee then elects whether to use Continuation of Pay and enters the date that the claim is being entered into the EDI application.

I hereby authorize any physician or hospital (or a medical carrier) to release any information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date MM-DD-YYYY 01-20-2005

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_C1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Enter a witness statement in this space. The witness will sign the statement when the claim form is printed.

If there is no statement, leave this space blank.

If the statement will not fit into the space annotate "witness statement forwarded under separate cover" in this space and fill out the witness information. Send the separate signed witness statement to the ICPA.

Last Name
Name of Witness:

First Name

Middle Name

MM-DD-YYYY
Signature of witness: Date signed:

Street Address:

City:

State: ZIP Code:

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

17. Agency name and address of reporting office

Agency name: GOVERNMENT AGENCY

Street Address: 123 WORK STREET

City: ANYTOWN

State: FL ZIP Code: 32006

18. Employee's duty station

Street Address: GOVERNMENT AGENCY

City: ANYTOWN

State: FL ZIP Code: 32006

19. Employee's retirement coverage

CSRS FERS OTHER (identify) [REDACTED]

20. Regular work hours

From: 09:00 AM To: 05:30 PM

21. Regular work schedule

Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

22. Date of injury

MM-DD-YYYY
01-20-2005

23. Date notice received

MM-DD-YYYY
01-20-2005

24. Date & time employee stopped work

MM-DD-YYYY HH:MM [AM|PM]
[REDACTED]

Enter the required information in the appropriate fields. Paying attention to the format for data entry. (No military time)

Record: 1/1

Warning: Applet Window

EDI FORM

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CAI

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

25. Date pay stopped
MM-DD-YYYY
[Yellow Box]

26. Date 45 day period began
MM-DD-YYYY
[Yellow Box]

27. Date & time employee returned to work
MM-DD-YYYY HH:MM [AM|PM]
[Yellow Box]

28. Was employee injured in performance of duty?
 Yes No (If "No", explain)

If the supervisor does not believe the employee was injured in performance of duty, "no" should be checked and the facts that support that position should be provided. Otherwise leave the box checked "yes."
If the information will not fit into this box, annotate "additional information forwarded under separate cover" and send the information to the ICPA to forward to OWCP.

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?
 Yes (If "Yes", explain) No

If the supervisor believes that willful misconduct was involved, "yes" should be checked and the facts that support this position provided. Otherwise leave the box checked "no"
If the information will not fit into this box annotate "additional information forwarded under separate cover" and send the information to the ICPA to forward to OWCP.

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

30. Was injury caused by third party?

Yes
 No

31. Name and address of third party (include city, state, and ZIP code)

3rd party name: [REDACTED]
name continued: [REDACTED]
Street Address: [REDACTED]
City: [REDACTED]
State: [REDACTED] ZIP Code: [REDACTED]

32. Name and address of physician first providing medical care (include city, state, and ZIP code)

Last Name [REDACTED] First Name [REDACTED] Middle Name [REDACTED] Title [REDACTED]
Street Address: [REDACTED]
City: [REDACTED]
State: [REDACTED] ZIP Code: [REDACTED]

33. First date medical care received

MM-DD-YYYY [REDACTED]

33a. Provided by Agency medical facility?

Yes No

Example of a third party claims would be an automobile accident in which the other driver was found to be at fault.

If the individual was treated at an agency facility the information in Block 32 must be provided (unique to EDI/SAFER)

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CAI

ORACLE

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

Yes No (If "No", explain)

If, in the investigation of the claim, nothing contradicting the employee or witness is uncovered, it would be appropriate to answer "yes". The supervisor does not have to witness the alleged incident to answer "yes". If an investigation has been started, but the results are not available at the time of claim filing, then annotate "investigation in progress, results forwarded under separate cover". The ICPA should be provided with a copy of the results to forward to OWCP

36. If the employing agency contests continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work

Amount: Per: <not entered>

Record: 1/1 ...

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

Yes No (If "No", explain)

If the agency wishes to challenge the claim, then "no" must be selected for this item and the reasons for the challenge entered into this space. If the information will not fit, then annotate "additional information will be forwarded under separate cover" and forward the information to the ICPA

36. If the employing agency contests continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work

Amount: <not entered>

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CAT

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 **Sup Rpt 4** Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

Yes No (If "No", explain)

36. If the employing agency converts continuation of pay, state the reason in detail.

Enter the reason for the conversion of COP in this space.

37. Pay rate when employee stopped work

Amount: Per:

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CAI

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

Work Environment Exceptions

Employee was member of general public.

Injury resulted from non-work related event.

Injury resulted from voluntary participation.

Injury resulted from employee eating.

Injury resulted from personal grooming.

Injury resulted from a motor vehicle accident.

Injury is the common cold or flu.

Check all that apply for the sections on this tab. This information will be used to generate the OSHA 301 notice used for safety notification (Unique to EDI/SAFER) and will not be sent to OWCP.

Privacy Case Status: A Not A Privacy Case

General Recording Criteria

Employee is deceased as a result of the incident.

Employee suffered days away from work as a result of the incident.

Employee's work activity was restricted as a result of the incident.

Employee was treated in an emergency room as a result of the incident.

Employee was hospitalized overnight as an in-patient.

Employee lost consciousness as a result of the incident.

Employee was transferred to another job as a result of the incident.

Preliminary OSHA Recordability

29 CFR 1960: RECORDABLE

OSHA 200 Log Coding: 6

29 CFR 1904: RECORDABLE

OSHA 300 Log Coding: J,1

As Of: 01-20-2005 02:53:38 PM

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, or omission in this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS

If an on-site investigation was performed then a root cause will have to be entered.

Was an on-site investigation conducted?

Yes No

What was the root cause of this injury?

Last Name: SUPERVISOR

First Name: JOE

Middle Name:

Date signed: 01-20-2005

MM-DD-YYYY

Supervisor's Title: SUPERVISOR

Supervisor's Email Address: **jsupv@govt.mil**

Supervisor's Office phone number: 1234567890

Signature of supervisor:

Supervisor's Title: SUPERVISOR

Supervisor's Email Address: **jsupv@govt.mil**

Supervisor's Office phone number: 1234567890

39. Filing Instructions

No lost time and no medical expense: Place this form in employee's mail.

No lost time, medical expenses incurred or expected: forward this form to **jsupv@govt.mil**

Lost time covered by leave, LWOP, or COP: forward this form to OWCP

First Aid Injury

The supervisor's email address should be entered in this field.

View Claim **Submit Claim** **Cancel** **Exit**

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

Yes No

What was the root cause of this injury?

Last Name: Name of Supervisor: **SUPERVISOR**

First Name: **JOE**

Middle Name: **MM-DD-YYYY**

Date signed: **01-01-2005**

Signature of supervisor: **SUPERVISOR**

Supervisor's Title: **SUPERVISOR**

Supervisor's Email Address: **jsupv@govt.mil**

Supervisor ID: **1234567**

39. Filing Instructions

No lost time and no medical expense: Place this form in employee's personnel file.

No lost time, medical expenses incurred or expected: forward this form to the supervisor.

Lost time covered by leave, LWOP, or COP: forward this form to the supervisor.

First Aid Injury

Verify the email address

Email Validation: Please re-type your email address here, before you can continue, then press OK.

jsupv@govt.mil

OK

View Claim **Submit Claim** **Cancel** **Exit**

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

ORACLE

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

Yes No

What was the root cause of this injury?

Name of Supervisor: **SUPERVISOR**

Last Name: **JOE**

First Name: **JOE**

Signature of supervisor: _____

Supervisor's Title: **SUPERVISOR**

Supervisor's Email Address: **jsupv@govt.mil**

Supervisor's Office phone number: **1234567890**

Date signed: **01-20-2005**

39. Filing Instructions

No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)

No lost time, medical expenses incurred or expected: forward this form to OWCP

Lost time covered by leave, LWOP, or COP: forward this form to OWCP

First Aid Injury

Select the appropriate filing instructions.

View Claim **Submit Claim** **Cancel** **Exit**

Record: 1/1 ...

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

Yes No

What was the root cause of this injury?

Last Name: Name of Supervisor: **SUPERVISOR**

First Name: **JOE**

Middle Name

MM-DD-YYYY Date signed: **01-20-2005**

Supervisor's Title: **SUPERVISOR**

Supervisor's Email Address: **jsupv@govt.mil**

Supervisor's Office phone number: **1234567890**

39. Filing Instructions

No lost time and no medical expense: Place this form in employee's medical file.

No lost time, medical expenses incurred or expected: forward this form to OWC.

Lost time covered by leave, LWOP, or COP: forward this form to OWC.

First Aid Injury

Select the View Claim button

View Claim **Submit Claim** **Cancel** **Exit**

Record: 1/1 ...

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_C1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Was an on-site investigation conducted? Yes No

What was the root cause or contributing factor(s) to this injury?

Last Name: SUPV, First Name: MR, Middle Name: (Redacted)

Name of Supervisor: SUPV, MM-DD-YYYY: 04-13-2006

Signature of supervisor: (Redacted)

Supervisor's Title: SUPERVISOR, Supervisor's Email Address: supv@agency.gov, Supervisor's Office phone number: 1234567890

Required Submission (Redacted)

What would you like to do?

View Claim for Printing and Submit to ICPA

View Draft Copy of Claim to Verify Data

View Claim, Submit Claim, Cancel, Exit

Record: 1/1

Once the **View Claim** button is selected, a dialog box will open providing two options.

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CAI

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

ORACLE

The **View Claim for Printing and Submit to ICPA** option allows the claim to be viewed and printed as a .pdf file and then sent to the ICPA without any further action by the user.

The **View Draft Copy of Claim to Verify Data** option allows the claim to be viewed and printed as a .pdf file but the user must then select the **Submit Claim** button to send the claim to the ICPA.

Name of Supervisor: MIR MM-DD-YYYY Date signed: 04-13-2006

Signature of supervisor:

Supervisor's Title: Supervisor's Email Address: Supervisor's Office phone number:

Required Submission:

What would you like to do?

Record: 1/1

EDI FORM

Acrobat Reader - [rwserver[2].pdf]

File Edit Document Tools View Window Help

Review the claim. If the information is correct, select the print icon and print the claim. The employee, supervisor, and witness should then sign their portion. The signed copy is forwarded to the ICPA for record retention.

Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of Employee (Last, First Middle Suffix) SMITH JOHN	2. Social Security Number 111111111		
3. Date of Birth 01/01/1960	4. Sex MALE	5. Home Telephone 123456789	6. Grade as of date of injury Level WG10 Step 06
7. Employee's home mailing address (include city, state, and ZIP code) 123 MAIN STREET ANYTOWN FL 32006			8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 year <input type="checkbox"/> Other
Description of Injury			
9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine) MAIN OFFICE BUILDING, 123445 WORK STREET, ANYTOWN FL FLEMING ISLAND FL			
10. Date injury occurred 01/20/2005 02:30 PM	11. Date of this notice 01/20/2005	12. Employee's job title MAIL CLERK	
13. Cause of injury (Describe what happened and why) I WAS WALKING DOWN THE STAIRS AND I TRIPPED AND FELL			

1 of 8 10 x 11 in

EDI FORM

EDI DIUCS v2.1 EDI

Window

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

Yes No

What was the root cause of this injury?

Last Name: **SUPERVI** First Name: Middle Name:

Name of Supervisor: **SUPERVI**

Signature of supervisor: _____

Supervisor's Title: **SUPERVISOR**

39. Filing Instructions

No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
 No lost time, medical expenses incurred or expected: forward this form to OWCP
 Lost time covered by leave, LWOP, or COP: forward this form to OWCP
 First Aid Injury

If the *View Draft Copy of Claim to Verify Data* option was selected, the **Submit Claim button must be selected on order to transmit the claim to the ICPA.**

View Claim **Submit Claim** **Cancel** **Exit**

FRM-40400: Transaction complete: 1 records applied and saved.
Record: 1/1 ...

Warning: Applet Window

SUMMARY OF SUPERVISOR ACTIONS

- Supervisor accesses the EDI application through the “Filing Claims Electronically” link on the ICUC Web page.
- Supervisor enters the SSN and Date of Birth of the employee and selects whether a CA-1 or CA-2 will be filed
- Employee information is entered onto the form
- Witness information is entered (if applicable)

SUMMARY OF SUPERVISOR ACTIONS

- Supervisor enters required information in Supervisors portion of the form
- The form is printed. The employee, witness and supervisor sign their respective sections.
- “Submit Claim” button is selected and claim is sent electronically to the ICPA.
- Signed claim form is sent to the ICPA to be retained in the file